

## Welcome to Oriental Medicine Clinic

Would you please take a moment to provide us some information about yourself and your health conditions, so that we may do our best to treat you. Yes Acupuncture & Wellness Center considers this information privileged physician/ patient communication and with holds it in confidence. If you have any question, please don't hesitate to ask for assistance. **Please Print**

Date: _____	
Name: (Last) _____ (First) _____ (Middle) _____	
Sex: M F	Birth Date: _____ Age: _____
Home Address: _____	
City _____	State _____ Zip _____
Phone: (H/C) _____	(W) _____ Email _____
Marital Status:    Single    Married    Widowed    Divorced    Separated	
Spouse's Name: _____ Phone: (W) _____	
Patient employed by _____	
Occupation _____	Business Phone: _____
In case of emergency who should be notified? _____	
Relationship _____	Phone _____
Address _____	
Have you received acupuncture before? _____ How did you hear about us? _____	
Your medical doctor's name (Western) _____ Phone: _____	
Diagnosis of your problems _____	

### **Treatment Agreement**

I come here, to Yes Acupuncture Clinic, seeking Chinese Medical treatment for my condition. I hereby authorize \_\_\_\_\_ to perform appropriate therapy as my condition indicates or requires. I understand that these therapies may not be commonly accepted or known to my community or to myself. But that they are based on centuries old medical systems from around the world. I understand that Acupuncture, herbs and related treatments, as in any medical therapy, may make no guarantee to the results.

I understand that only one-time use, pre-sterilized disposable needles are used at Yes Acupuncture & Wellness Center.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Please go to page 2

**PATIENT HISTORY**

What is your major complaint? \_\_\_\_\_

How did this condition develop? \_\_\_\_\_

How long has this condition persisted? \_\_\_\_\_

Have you ever received any treatment for this condition?  Yes  No

If yes, where? \_\_\_\_\_ By whom? \_\_\_\_\_ When? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What kind of treatment(s)? \_\_\_\_\_

Was the result satisfactory? \_\_\_\_\_

Please list substance that you are allergic to: \_\_\_\_\_

(Female only) Are you pregnant or do you suspect that you may be pregnant? \_\_\_\_\_

List medications you are currently taking:

Medications	Strength	How many per day	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received any treatment for this condition?  Yes  No

List any major surgeries you had:

Date	Problem
_____	_____
_____	_____
_____	_____
_____	_____

Significant illness (Please check):

- High Blood Pressure     Rheumatic fever     Hepatitis     Diabetes
- Thyroid disease     Coagulopathy     Seizure     AIDS
- Hyperlipidemia     Tuberculosis     Cancer     Stroke
- Others \_\_\_\_\_

Significant Trauma (auto accident, falls. etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Form to be Completed by Patient, Notifying the Acupuncturist of Whether He/She Has Been Evaluated by a Physician, and Other Information**

(Pursuant to the requirements of '183.6(e) of this title (relating to Denial of License; Discipline of Licensee) and Tex. Occ. Code Ann., '205.351, governing the practice of acupuncture.)

I (patient's name) \_\_\_\_\_, am notifying the  
acupuncturist (practitioner's name), \_\_\_\_\_  
of the following:

\_\_\_\_\_ Yes \_\_\_\_\_ No

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

\_\_\_\_\_ (Initials of patient) Date: \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 120 days or 30 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Note:

**Exemptions according to Rule 183.6 (e) Scope of Practice**

3) ...an acupuncturist holding a current and valid license may perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

## Consent to Treatment Form

I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine at Hsien-Min Yeh L.Ac./

Chiung-Hui Tseng L.Ac./ Julie Chen L.Ac./ John Fain L.Ac./ Maria Posa L.Ac./ Johathan Stuart L.Ac./ David Chi Yu Chen L.Ac.

**(Initial)\_\_\_\_\_Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of sterile single use needles through the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effect may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**(Initial)\_\_\_\_\_Pregnancy:** I will notify the treating provider should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

**(Initial)\_\_\_\_\_Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**(Initial)\_\_\_\_\_Acupuncture, Tui-Na Massage, Qi Gong:** I understand that I may also be given acupuncture/Tui-Na massage and/ or Qi Gong as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**(Initial)\_\_\_\_\_Cupping, Gua Sha, Lance Therapy:** I understand that I may also be given cupping (the application of plastic cups with vacuum to the skin), Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon), lance therapy (using a lance to remove stagnant blood) as part of my treatment to modify or prevent pain perceptions and to normalize the body's physiological functions. **I am aware that these treatments are intended to cause minor bruising, and though unsightly, are not normally painful.** However, certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at any time for any reason.

**(Initial)\_\_\_\_\_Treatment by Trainees:** I understand that I may have treatment performed by an acupuncture trainee supervised by Hsien-Min Yeh L.Ac. Before any treatment by trainee is performed, the patient will be verbally notified and asked by said trainee. I understand that I may refuse treatment by the trainee for any reason.

**(Initial)\_\_\_\_\_** I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I do not expect Acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in and emergency or by legal demand). I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_